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Four Models of Medical Education about Elder Mistreatment

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ABSTRACT

The authors describe four models of incorporating elder-mistreatment curricular content and collaboration with adult protective service (APS) community service agencies into geriatrics medical education. Geriatrics education programs at four academic health centers—the University of Medicine and Dentistry of New Jersey–Robert Wood Johnson Medical School; the University of California, Irvine College of Medicine; Hennepin County Medical Center, Minneapolis, Minnesota; and Baylor College of Medicine Geriatrics Program at the Harris County Hospital District, Houston, Texas—were surveyed and information collated.

All programs incorporated direct interactions between learners and APS workers into their teaching programs. Learners were fellows, residents, and medical students. While two programs provided direct patient care, two others restricted learners to consultant roles, supporting the APS service providers with medical input. In addition to directly meeting curricular training needs of elder abuse and neglect, clinical cases provided valued learning experiences in applied clinical ethics, the role of physicians with community-based programs, the interaction between the medical and legal professions in cases of financial exploitation, and assessment of elder individuals' decision-making capacity. In two programs APS workers also contribute to the assessment of trainees' humanistic competencies. The authors conclude that APS community service agencies can successfully be incorporated into medical training programs to address a wide range of curricular goals.

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The abuse or neglect of the aged and vulnerable adults in our society has existed for years. Physicians' awareness and response have gradually increased only since the 1970s, when reports of "granny battering" first appeared.[1] Most physicians have poor understanding of the reporting and investigative mechanisms related to this type of abuse. In 1986, the Older Americans Act began the process of an organized governmental response, coordinated at a state level and administered through local area agencies on aging or county social service units.[2] An important element in many of the states' responses was mandatory reporting of acts of elder abuse by those coming into contact with susceptible populations, including physicians. Adult protective service (APS) agencies were established to respond to such reports. Limited interactions between APS agencies and physicians presently occur, as physicians rarely are the reporting source of abuse or neglect circumstances.[3] With increasing research demonstrating the devastating health impact of elder mistreatment, however, greater involvement of physicians with APS activities will be necessary.[4,5]

Within medical education, there exists a need for both greater ambulatory-based training experiences in general and content focused specifically on elder mistreatment. In a study of residency programs in Virginia, only 9% presented con-

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tent in elder abuse.[6] We suspect this continues to be a content area underrepresented in the curricula of most postgraduate physician training programs. While 77% of medical school deans in an AAMC study reported some specific elder mistreatment curricula, surveys of medical school graduates report that only 38% of graduates recall being taught about this topic during their training.[7] Linking academic training programs with community service agencies such as APS is one model for geriatric education in this important content area that can also help address community-based training needs.

The educational objectives for such interactions focus on enhanced awareness of the problem of elder abuse and neglect and the role physicians ought to play in recognizing and responding to such circumstances. Though such interactions remain rare within academic training programs, we present four geographically distinct and independent approaches to establishing such an educational collaborative relationship within our respective communities APS units. As the administrative approaches and organizations of these independent adult protective service agencies differ greatly due to differences in states' enabling legislation and organizational structures, we first present the distinctive characteristics and then the commonalities of these relationships.

FOUR MODELS OF COLLABORATION

University of California, Irvine

The Program in Geriatrics at the University of California, Irvine (UCI) College of Medicine is a multidisciplinary, interdepartmental entity formed in 1985 that has among its duties the design and implementation of the geriatrics block rotation required for family medicine residents. All family medicine residents spend time with the county APS unit during their one-month geriatrics block rotation. After meeting an APS supervisor at her office for an orientation to the agency, the resident accompanies a worker in the field for one-half day. Together the APS worker and the resident perform several house calls to investigate possible abuse or neglect. Residents also attend two monthly meetings, organized by the county. One, the multidisciplinary team meeting (MDT), is attended by representatives from APS, law enforcement, the district attorney's office, and social service agencies, along with a geriatrician and psychologist from UCI. This MDT reviews cases of physical abuse and neglect that are particularly difficult and would benefit from a thorough interdisciplinary review in order to proceed. The Fiduciary Abuse Specialist Team has representation from APS, lawyers, bankers, real estate specialists, psychologists, and social service agencies, as well as a geriatrician from UCI. From this team the resident hears about the intricate and complicated ways in which elders are victims of financial abuse. Following these team meetings the resident and the geriatrician discuss some "take home messages" that the resident may use from the meetings. Throughout the month-long rotation, the attending geriatricians reinforce these concepts and describe how to apply them in the office setting. Residents and fellows learn about their legal obligations should they suspect abuse, how to file a report, and what to expect from APS in response to the report.

Hennepin County Medical Center

An experience with Hennepin County Adult Protective Services (in Minneapolis, Minnesota) has been a formal component of the required one-month rotation in geriatrics for Hennepin County Medical Center (HCMC) internal medicine residents since 1996, and more recently a requirement for University of Minnesota second-year residents in obstetrics–gynecology. It is also an integral part of the ongoing training of geriatrics fellows. At the start of each rotation residents and fellows are informed about their responsibilities for the APS component by the geriatrics program director and the social work unit supervisor at the APS Office as part of their overall orientation to the geriatrics rotation. Orientation topics include epidemiology of elder abuse and neglect; statutory reporting requirements and definitions, including self-neglect (which comprises the majority of cases reported to APS); APS powers and limitations; resident physicians' roles and faculty expectations; an overview of required readings; and a review of biomedical ethical principles,[8] with special emphasis on their relationship to self-neglecting vulnerable adults. Residents serve as consultants and advisors to county APS social workers as they jointly visit the homes of clients who have been reported as potential victims of abuse or neglect during a one-half-day-per-week session. Residents provide advice about the urgency of the medical component and perspectives about the client's capacity to decide in situations of refusal of suggested care or evaluations. They also can support APS legal actions in conservatorship hearings, and have been asked by court referees about the clients they have observed. While they interview clients in the home setting in the presence of the APS social worker, trainees do not provide direct, hands-on care and do not establish a doctor–patient relationship. Residents present cases in which they have been involved to geriatrics faculty physicians at a weekly conference in which biomedical ethical principles relevant to decision making about the vulnerable adult and other adult protection issues are discussed. The applicability of an ethics consultation framework to informing care decisions is reviewed.

Baylor College of Medicine

The Baylor College of Medicine Geriatrics Program of the Harris County Hospital District provides coordinated interdisciplinary geriatric care to the elderly of Harris County, Texas.[5] The Texas Department of Protective and Regulatory Services and Baylor have formed a cooperative relationship to provide care to mistreated elders in Harris County and to conduct research aimed at understanding risk factors and improving outcomes for victims. The elder mistreatment team members include geriatrics physicians, nurse practitioners, social workers, and APS specialists. Individuals reported to APS undergo investigations by the protective service specialist and then are referred to the geriatrics program for comprehensive geriatric assessment. All members of the elder mistreatment team meet then to develop a joint care plan. Residents from the family practice, internal medicine, and obstetrics–gynecology residency training programs, geriatrics fellows, physician assistants, and nurse practitioner students rotate in one-month blocks. Patients referred from APS agencies are seen in a hospital-based ambulatory clinic, on house calls, or in the acute care hospital. Trainees learn to perform geriatric assessment while dealing with complex ethnical issues and working within an interdisciplinary team.

UMDNJ–Robert Wood Johnson Medical School

The Department of Family Medicine at the Robert Wood Johnson Medical School of the University of Medicine and Dentistry of New Jersey established a home-based geriatric assessment team serving clients of the APS agency in Middlesex and Somerset counties of central New Jersey. The program, called Linking Geriatrics to Adult Protective Services (LGAPS) was initially supported in part by The Robert Wood Johnson Foundation and based upon a collaborative practice of an adult nurse practitioner and geriatrician within the medical school's Department of Family Medicine's faculty practice. The APS social workers perform a case-finding function by identifying unmet health needs from among their new and existing clients of vulnerable adults and referring these individuals for assessment. Since 1998 assessments have been carried out in the home setting, involving any caregivers on-site. Direct patient care interventions are made, to include both direct health care measures and those involving medical support for the social work and/or legal interventions proposed by the APS agency to redress the abuse and or neglect circumstances. These in-home assessments are included as part of the formal curriculum for the family practice residents and geriatrics fellows in training programs affiliated with the medical school as well as with nurse practitioner students. Learners accompany the geriatrics clinicians on their home visits where the teaching encounter focuses on both the geriatric assessment process and the circumstances of the alleged elder mistreatment that prompted the initial referral.

Table 1 provides a summary of the features of each of these educational linkages between an academic institution and APS providers in the community setting.

COMMONALITIES AND DISTINCTIONS

We have described these academic programs, independently developed in four disparate regions of the United States, to stimulate similar community-based educational collaborations elsewhere. While each evolved within the unique environment of its state's elder mistreatment statutes and APS function and its own geriatrics faculty's interests, they share the common medical educational goal to expand geriatrics training in the community setting. The cross-disciplinary involvement of participating nurse practitioners and other advance practice nurses at two sites and of social workers at all sites provides an important opportunity for physicians in training to interact among other health professionals. All programs also have established some debriefing where the learner has an opportunity to review his or her experiences with the APS workers and the mistreated individual clients. This interaction is used at UCI to explicitly review the circumstances of neglect and exploitation cases. At HCMC in Minneapolis, the educational focus often centers on conflicting biomedical ethical principles applicable to cases of self-neglect, which is considered a subset of the broader topic of patient refusal of recommended care. All sites also use supplementary reading materials, focused on elder mistreatment issues as well as any relevant clinical issues that have arisen in the experience (e.g., ethical framework for decision making.)

An important distinction between these programs is in the natures of clinical service provided to the APS agencies and their clients. At the New Jersey and Texas training sites, direct patient care services are provided as part of a medical geriatric assessment process, conducted in both the home and the outpatient clinic setting. In the California and Minnesota training sites, residents provide consultative advice to the APS workers regarding the urgency of the situation, recommend medical referral services, communicate with pre-existing primary care providers, refer to the multidisciplinary geriatrics clinic for assessment, or in extreme situations facilitate APS petitions for involuntary health care institutionalization. In the latter two training settings, direct physician–faculty supervision of each interaction is not required, as trainees serve only as consultants to the APS workers. The resident neither provides direct hands-on clinical care nor establishes a doctor–patient relationship with the APS client. The decision to provide direct patient care to APS clients while learners are present has implications

Table 1

Adult Protective Services (APS)-based Educational Collaborations at Four Academic Institutions

Site	Level of Learners	Clinical Service Provision	Curricular Formats	Curricular Content Features	Organizational Unit Coordinating APS Interactions	Affiliation between APS and Academic Unit
Hennepin County Medical Center Minneapolis, MN	Geriatric fellows Internal medicine and ostetrics–gynecology residents	Geriatric medical consultant for APS; no doctor–patient relationship established	Home visits with APS workers Weekly geriatric faculty case conferences Fellows "on call" for APS consults	Biomedical ethics of elder mistreatment (e.g., autonomy, decision-making capacity, beneficence, nonmaleficence)	County hospital-based training program in internal medicine and geriatrics	Joint resident–APS social worker house calls Residents serve as consultants to APS staff on medical matters
University of California at Irvine Irvine, CA	Geriatric fellows Family practice residents Medical students	Geriatric medicine consultant for APS workers; no doctor–patient relationship established Learners provide no direct patient care services	Home visits with APS workers Multidisciplinary team meeting Fiduciary abuse specialist team meetings	Physician's role interacting with law enforcement role Exploitation and financial abuse circumstances	Interdepartmental program in geriatrics at medical school	Joint resident–APS social worker house calls Support to provide mandated training programs
University of Medicine and Dentistry of New Jersey–Robert Wood Johnson Medical School New Brunswick, NJ	Geriatric fellows Family practice residents Medical students Nurse practitioner students	Geriatric assessment house calls of referred APS clients Geriatric medicine input/consultation to APS workers	Home visits with faculty clinicians Readings	Geriatric assessment process Modeling nurse practitioner–physician collaborative practice	State university medical school Department of Family Medicine's geriatric fellowship program	Educational affiliation agreement with county APS agencies Clinical patient care billings and contractual fees for legal assessments provided to county's APS agencies
Baylor College of Medicine–Harris County Hospital District Houston, TX	Geriatric fellows Internal medicine, obstetrics–gynecology, and family practice residents Medical students Nurse practitioner and physician assistant students	Geriatric assessment hospital-based outpatient clinic and/or house calls on referred APS clients	Clinic/home visits with faculty clinicians Interdisciplinary team meetings Didactic teaching and syllabus	Medical problems seen in mistreated elders Geriatric assessment process Loss of executive functioning related to self-neglect circumstances Ethnical dilemmas	Harris County Hospital District's geriatrics program	State-wide Institute for Abuse and Mistreatment with the Texas Department of Protective Services Clinical billings for patient care services provided to APS clients

for the financing of such educationally-centered interactions, requiring the on-site availability and active participation of faculty clinicians needed for third-party insurance billings of any clinical patient care services. This can also involve contractual financial compensation to the training program, as is the case at the New Jersey site, where written medical assessment documentation is provided in support of county legal actions on behalf of those APS clients requiring incapacity hearings and guardianship appointments.

LESSONS LEARNED

The collaboration between medical education programs and APS agencies provides a valuable presence and identity for each training program in its respective community. For most learners, it is their first exposure to the issue of elder mistreatment. Residents' evaluations—especially from those in primary care fields—reflect both enthusiasm for their interactions with APS workers and varying degrees of shock with witnessing the living circumstances of many neglected APS clients. Residents also report greater appreciation of the broad range of living situations, care circumstances, and limited access to medical services many APS clients experience. The enhanced attitudes and skills of the residents—such as assessing decision-making capacity, working with patients who refuse recommended evaluations or interventions, and helping negotiate acceptable plans of care obtained through this experience—are germane to all medical care settings.

For their part, APS caseworkers are enthusiastic about precepting residents and perceive a significant added value to their client interactions from the educational collaboration. Across all settings, the participating APS specialists from social work and other disciplines gain a better appreciation of the role medical providers can play in providing case-specific relevant medical knowledge. This interdisciplinary dialogue of community-based medical educational partnerships is valuable for medical learners to experience.[9,10] In two of the settings, APS workers can directly contribute to the evaluation of the trainees' humanistic qualities. An especially designed form incorporating evaluation of the resident's humanistic qualities, team skills, and professional attitudes and behaviors has improved the trainee evaluation process for these required competency-based evaluation elements from these educational collaborations.

REPLICATION ISSUES

A common difficulty in the implementation of such programs has been the challenge of coordinating the learner's availability with that of the faculty and with the unpredictability of the client's clinical needs. At the UMDNJ training site, this has been resolved in part by having the fellows or resident learners accompany the participating clinicians in those return home visits to APS individuals whose initial assessments have already taken place. Another important challenge has been the balance needed of the teaching attending physician to model the clinical skills and knowledge base required to make efficient house calls caring for abused or neglected elders while also providing time to debrief the learner about the experience, away from the house call or the clinic site. It has also been important that scheduling information for both sites—the APS unit and the training program's involved teaching clinicians—is shared with a designated contact person.

An important first step for each of the training programs described here was the identification of enthusiastic partners at the academic institution and within the APS agency who were empowered to establish educational collaborations with training programs. There are significant differences between the institutional cultures that need to be recognized and dealt with. Another important step is establishing a formal educational affiliation agreement that explicitly recognizes the APS workers as providing valid educational experiences that are defined as part of the learner's educational program and therefore covered by the liability and related insurance coverage of the training programs. This affiliation agreement can also specify the assignment of responsibility for evaluation and learner feedback.

CONCLUSION

The above descriptions of four models of effective educational collaborations with community-based service agencies show that learners from multiple levels of varied health professional training programs are able to gain valuable experiences in geriatric care, particularly issues of elder mistreatment. We hope other training programs will be able to use aspects of these models in planning their own collaborative programs in geriatrics education.

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Cover Note

CASE WESTERN RESERVE UNIVERSITY SCHOOL OF MEDICINE

Since its founding in 1843, the Case Western Reserve University (CWRU) School of Medicine has been at the forefront of medical education and research.

In 1852, the medical school became the second allopathic medical school to graduate a woman, Nancy Talbot Clarke. During the next four years, five more women were to graduate from the school, giving it the distinction of graduating six of the first seven female allopathic physicians in the United States.

The school was one of the first to employ instructors devoted to full-time teaching and research, and in 1888, it offered the first required laboratory course in physiology in the United States. In 1910, Abraham Flexner named Western Reserve University (the former name of CWRU) as second only to Johns Hopkins as the best medical school in the country. It drew many faculty from Hopkins in the decade prior to that report.

In 1952, the School of Medicine initiated the most progressive medical curriculum in the country at that time, integrating the basic and clinical sciences. The multidisciplinary program presented integrated views of studying the body, gave students clinical experience in their first year of school, and cultivated students' sensitivity toward the whole patient, the patient's family, and the social context of illness.

Historic research highlights include: Development of the modern technique for human blood transfusion using a cannula to connect blood vessels; first large-scale medical research project on humans in a study linking iodine with goiter prevention; pioneering use of drinking water chlorination; discovery of the cause of ptomaine food poisoning and development of serum against it and similar poisons; first surgical treatments of coronary artery disease; discovery of early treatment of strep throat infections to prevent rheumatic fever; development of an early heart–lung machine to be used during open-heart surgery; discovery of the Hageman factor in blood clotting, a major discovery in blood coagulation research; first description of how staphylococcus infections are transmitted, leading to required hand-washing between patients in infant nurseries; first description of what was later named Reye's syndrome; research leading to FDA approval of clozapine, the most advanced treatment for schizophrenia in 40 years at the time; discovery of the gene for osteoarthritis; and creation with Athersys, Inc., of the world's first human artificial chromosome. Today the CWRU School of Medicine is the largest biomedical research institution in Ohio and the 14th largest in the nation, as measured by funding received from the National Institutes of Health.

Ten years ago, CWRU School of Medicine became the first medical school to provide laptop computers to all of its students. Coupled with wireless zones throughout the medical school, the laptops today allow students to access an electronic curriculum, offering lecture notes, video streaming, and enhanced graphics. This technology enhances faculty–student interaction occurring in classrooms and laboratories.

The School of Medicine has eight Nobel Prize holders among its alumni and former and current faculty, as well as two graduates who have distinguished themselves as U.S. Surgeons General: Jesse Steinfeld, MD, and David Satcher, MD, PhD.

GEORGE STAMATIS
Director, Public Affairs
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Teaching and Learning Moments

The Length of Our Journey: Care Near the End of Life

As an intern and resident, I was virtually confined to caring for hospitalized patients. Learning about "care near the end of life" was, in retrospect, sadly simple-minded. My memories and notebooks bring to light nothing more than several lecture sessions dedicated to the "ABCs of resuscitation"—techniques to be applied in the event of cardiopulmonary arrest! We were also trained to deliver intracardiac injections of epinephrine, pericardiocentesis for electromechanical dissociation, and if there was any suspicion of a pericardial effusion or a history of a prosthetic valve, emergency thoracotomy and open-chest cardiac compression. This complete sequence had to be worked through before you could stand back from the bed and "declare the patient dead."

I realize that my jargon-laden terminology fails to convey the full horror of this sequence of actions as I experienced it. The first patient that I admitted to the hospital as an intern, a man suffering with an acute crisis of diabetes and its complications, died this way. I wasn't present when he was discovered pulseless and apneic, so others initiated the resuscitation attempt. Hearing the emergency page, I hurried up five flights of stairs to his room, but arrived after the resuscitation attempt was under way. Before we finished, he had an endotracheal tube, a subclavian line, multiple arterial punctures, and a crudely opened chest. I was covered, like others, with electrode paste and blood. When—for pity's sake—we stopped and stepped away from his bed, there was a sudden realization that we had mutilated his body as well as brutalized all the other patients in the four-bed room. Struggling to breathe, I left the room and took refuge behind the linen carts in the ward staff unisex bathroom. I stepped inside for solitude, only to find the charge nurse there and in similar distress. After a good cry, washing up, and a long hug, we were both able to come out of the closet.

When that patient's family arrived hours later, to view his body and discuss an autopsy, I was unable to speak with them. I was busy—but I was also ashamed and guilty. I knew that I had failed in my responsibilities to care for this patient in the only way I could after his death—by attending to his family in their grief, standing with them at the bedside, answering their questions, and speaking together of his life and death. At that moment, I knew that I would never cut open a chest again to engage in a useless attempt to raise the dead. Within the next two years, the practice fell into disfavor anyhow, when its futility became apparent.

Over the course of my internship, it was the nurses who taught me how to prepare myself, as well as the patients I had lost, for meeting with the family. I learned to stay after a patient had died to remove the tubes, needles, adhesive tape, and IVs. I would help to wash the body, change the sheets, compose the limbs, and close the eyes. I would walk around the room and talk with the other patients, asking them if they were all right and whether they would prefer to leave before the bereaved family entered, knowing that they would be separated only by thin curtains from this passage. When at all possible, I would move the body to another single room so that the family could have space and time as well as their privacy. Then the family and I would meet, talk, plan, and say goodbye. Then I could hold my head up. Then I was once again a physician.

—Thomas S. Inui, ScM, MD

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